ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2019 HSA PAYROLL DEDUCTION AUTHORIZATION

MEMBER INFORMATION					
LAST NAME			FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED	
STREET	CITY	ST	ZIP	COUNTY	
HOME PHONE	CELL PHONE		EMAIL		

MAXIMUM HSA CONTRIBUTION

Every year the Internal Revenue Service (IRS) sets maximum contribution limits for health savings accounts (HSAs). Failure to observe these limits may result in tax penalties. PayFlex is required to report HSA contribution information to the IRS. There are other contribution schemes but the maximum per payday will generally prevent an account holder from over contributing to their HSA. For additional information on Maximum HSA Contributions visit benefitoptions.az.gov.

HSA CONTRIBUTION			
Coverage Tier	**Employee Annual Contribution Maximum Limit**	**State Contribution**	**Annual IRS Contribution Maximum Limit**
Employee	$2,780.06	$27.69 per pay period Up to $719.94 annually[1]	$3,500.00
Employee + Adult	$5,560.12	$55.38 per pay period Up to $1,439.88 annually[1]	$7,000
Employee + Child			
Family			

[1]*Subject to effective date of enrollment and remaining pay periods.*

CALCULATE YOUR HSA AMOUNT PER PAY PERIOD

- Choose your total HSA Contribution Amount for 2019
  - Divide by 26 pay periods for a full year (New Hires: divide by how many pay periods are left in the year)
  - Example: $3,000 ÷ 26 = $134.61
- Total equals your Employee HSA Contribution Amount per Pay Period - enter this amount in the blank below.

COVERAGE TIER

- ❑ Employee
- ❑ Employee + Adult
- ❑ Employee + Child
- ❑ Family

I elect a **per pay period** HSA contribution of $_____

Payroll contributions for HSAs are taken pre-tax.

This authorization will remain in effect until a new authorization is received.

AUTHORIZATION: I am enrolled in the State of Arizona's High Deductible Health Plan and have no other medical coverage, including Medicare. I am eligible to open and contribute to a health savings account. I hereby request and authorize the State of Arizona to deduct from my pay the above-identified deduction and to forward it to my health savings account with PayFlex. I understand it is my responsibility to manage my contributions in accordance with federal guidelines based on my eligibility as well as my dependents. I also understand that using my HSA funds for expenses other than those deemed qualified may subject me to tax penalties.

Employee's Signature_____ **Date** _____

Return to your agency liaison or ADOA Benefit Services Division

Email: benefitsissues@azdoa.gov
Fax: 602-542-4744
Mail: ADOA-Benefit Services, 100 N 15th Ave, Suite 260, Phoenix, AZ 85007